What's Next for Public Health?

Presentation to Chelan-Douglas Health District Board

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PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND HEALTHIER WASHINGTON

When I arrived in 2003, CDHD had over 60 FTEs. Now we have about 40.

- Most of this erosion happened before the recession hit, so it's a long term problem.
- It's a statewide pattern, not a local one.
- At first, we focused on what to cut.
- As cuts got deeper, it became more a question of what to keep.
- In other words, what is the essential core of public health that we need to preserve?

Public Health is a basic responsibility of government. That's not controversial, but what exactly does it mean?

- What public health functions are not optional in any civilized community, in the same sense that basic law enforcement and an honest judicial system are not optional?
- What does a public health department bring to a state or county that is not otherwise available?

These are not rhetorical questions.

- **Public health leaders must answer these questions clearly.**
- **If we do not define ourselves in a meaningful way others can understand…**
- **…others will continue to do it for us in ways we do not like.**

Haven't We Tried To Answer These Questions Already?

- Yes, but it didn't work very well for this purpose.
- When you sit down with a group of public health experts and ask them to define the government's basic public health responsibilities…
- You end up with a list that includes everything the members currently do.
- Examples: 10 Essentials, 5930 Core Functions, etc.
- No health department has ever done anything that isn't included in these lists.

What is missing from these lists?

- BOUNDARIES.
- This matters because to rebuild public health – even to protect what we still have – we must be able to clearly explain the government's public health responsibilities – what's in, and what's out.

Public Health
In Search of Boundaries

- Needed – A clear and explainable principle (other than who happens to be on the latest committee) for determining what is basic governmental public health and what is not.
- Public health already has such a principle.
- **It comes from epidemiology, the basic science of public health.**

Epidemiology and the Population-Based Principle

- Epidemiology is the study of patterns of disease/disability in populations, as opposed to the study of diseases in individuals.
- Epidemiology is the basis for public health as a distinct field.
- Epidemiology's population-based principle can be used to define the boundaries of governmental public health.

What are Population-Based Public Health Functions?

- Population-based functions:
  - involve health interventions that serve mainly to protect a population from a health threat…
  - …rather than to address a particular individual's health needs.
  - In purely population-based interventions, the benefit is real but the individual beneficiaries cannot be identified.

Examples of Purely Population-Based Health Interventions

- **Preventing chronic disease thru health promotion.**
- **Communicable disease outbreak response.**
- **Protection of clean drinking water**.

If your local health department helps people make healthier lifestyle choices to prevent chronic disease, quickly controls infectious outbreaks, and makes sure your drinking water is safe, which of your neighbors didn't get sick as a result? You can't tell.

The benefit is real, but diffuse.

You can't identify the individuals who benefited directly. So whose insurance should be billed?

Population-based interventions lack individually identifiable beneficiaries

- The more population-based an intervention is, the less likely it is to be done by the private sector or the medical care system, because it is unclear who (other than the whole community) should pay for it.
- That is, the incentives that would produce an individual health care service through the private sector are missing.
- Population-based interventions usually have to be done by public health or another public entity if they're going to be done at all.

Some functions are mixed – partly population based, partly individual.

- Care of indigent TB patients who won't otherwise receive treatment.
  - Part of the purpose is to care for the patient.
  - But the reason public health does it (when no one else will) is to protect the community from a dangerous infectious disease.
- Many vaccines also fit this pattern.
  - The vaccine protects the individual.
  - But we're also interested in the community benefits of an adequate immunization rate.

The Population-Based Principle Defines Public Health's Boundaries

- Public health is unique within the U.S. health care system and within government in its mandate to address overall population health, and to consider health issues from the perspective of the entire community.
- **We are primarily responsible for the population-based functions not otherwise addressed by our individually-oriented health care system.**

It bears repeating:

- **The Population-Based Principle is important NOT for academic or abstract reasons, but for very practical ones:**
  - The more population-based a function is – and the less possible it is to identify individual beneficiaries – the less likely it is to get done by the medical care system or the private sector.
  - And the more likely it is left to the government or to public foundations, if it gets done at all.

We could rate public health functions on population-based characteristics, and use that to determine which are core functions, with a 3-part scale:

1. Extent to which this is a purely population-based function without individually identifiable beneficiaries.
2. Served by organizations other than PH?
3. Legally mandated for PH? (If so, it's in the core regardless of how pop-based.)

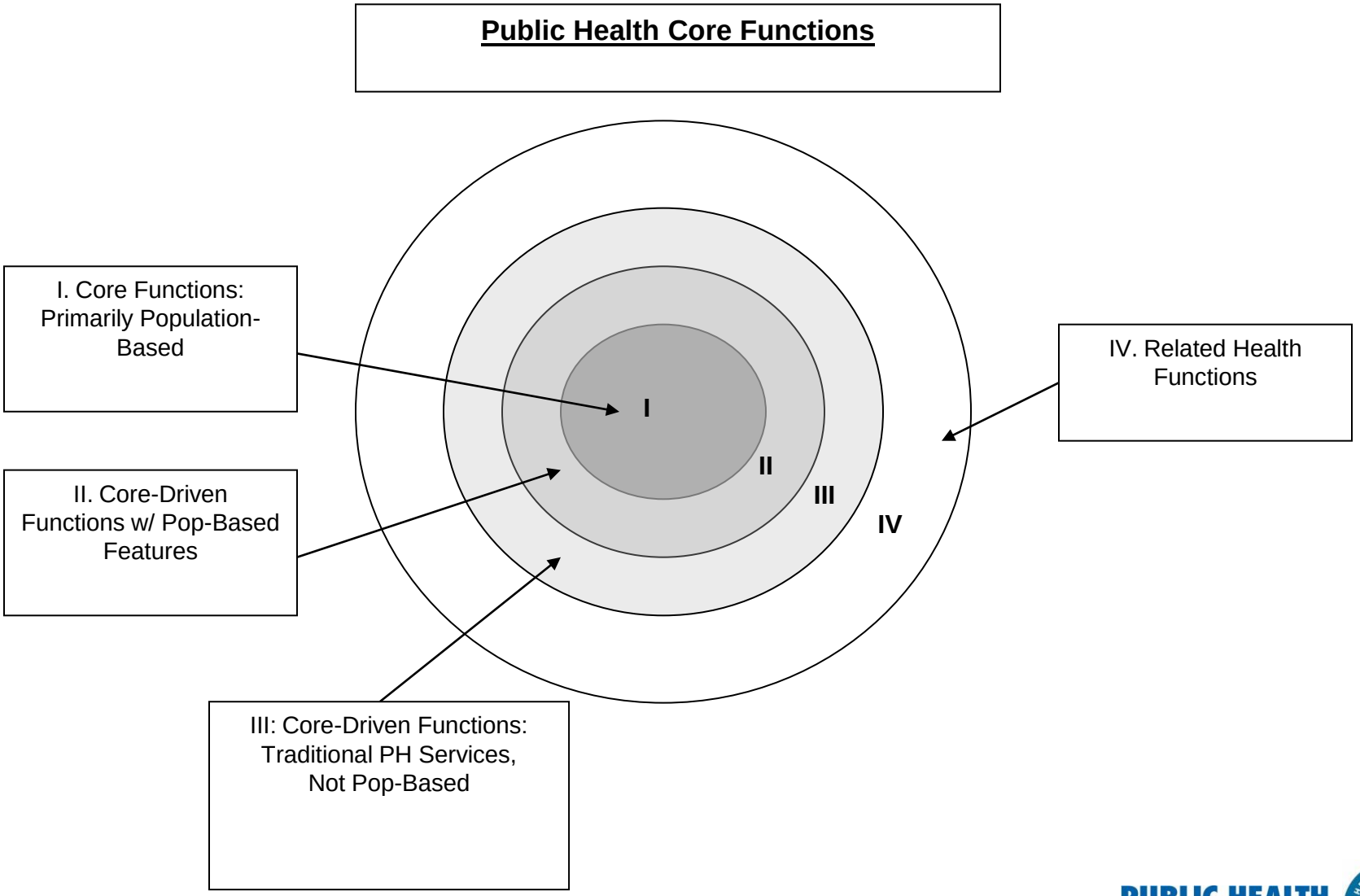
This scale can be used to define levels of governmental public health functions:

- **Level I – Core Functions** – population-based.
- **Level II – Core-Driven Functions** – with substantial population-based features.
- **Level III – Core-Driven Functions** – traditional public health services, not population-based.
- **Level IV – Related Health Functions** – within the competencies of public health when needed locally.

"Core-driven" means that a local health department capable of performing the Level 1 Core Functions will be driven to provide additional (core-driven) functions based on local need.

In the following lists of functions, each function is followed by its scores on the three question in brackets, as in [3,3,1].

Here's the obligatory diagram:



Level 1 Examples:
Core Population-Based Functions

- Morbidity, Mortality and Risk Factor Surveillance (Includes Reporting Notifiable Conditions) [3,3,3]
- Community Health Assessment [3,2,2]
- Policy Development and Advocacy [3,2,2]
- Public Health Emergency Preparedness/Response [3,3,3]
- Health Promotion/Disease Prevention
  - Outbreak/Case Investigation/Response (Includes I&Q) [3,3,3]
  - Immunization ***promotion*** [3,2,2]
  - Environmental Risk Reduction/Regulation [3,1,3] (Includes food safety, septic, drinking water, solid waste, etc.)
  - Community Health Education/Behavioral Risk Reduction [3,2,1] (Includes ***tobacco prevention***, obesity, injury prevention, etc.)

Level 2 Examples:
Core-Driven Functions with Substantial Population-Based Features

- Treatment/Management of dangerously infectious (e.g. TB) patients having no other access to care [2,1,2]
- Immunization ***clinics*** [2,1,1]

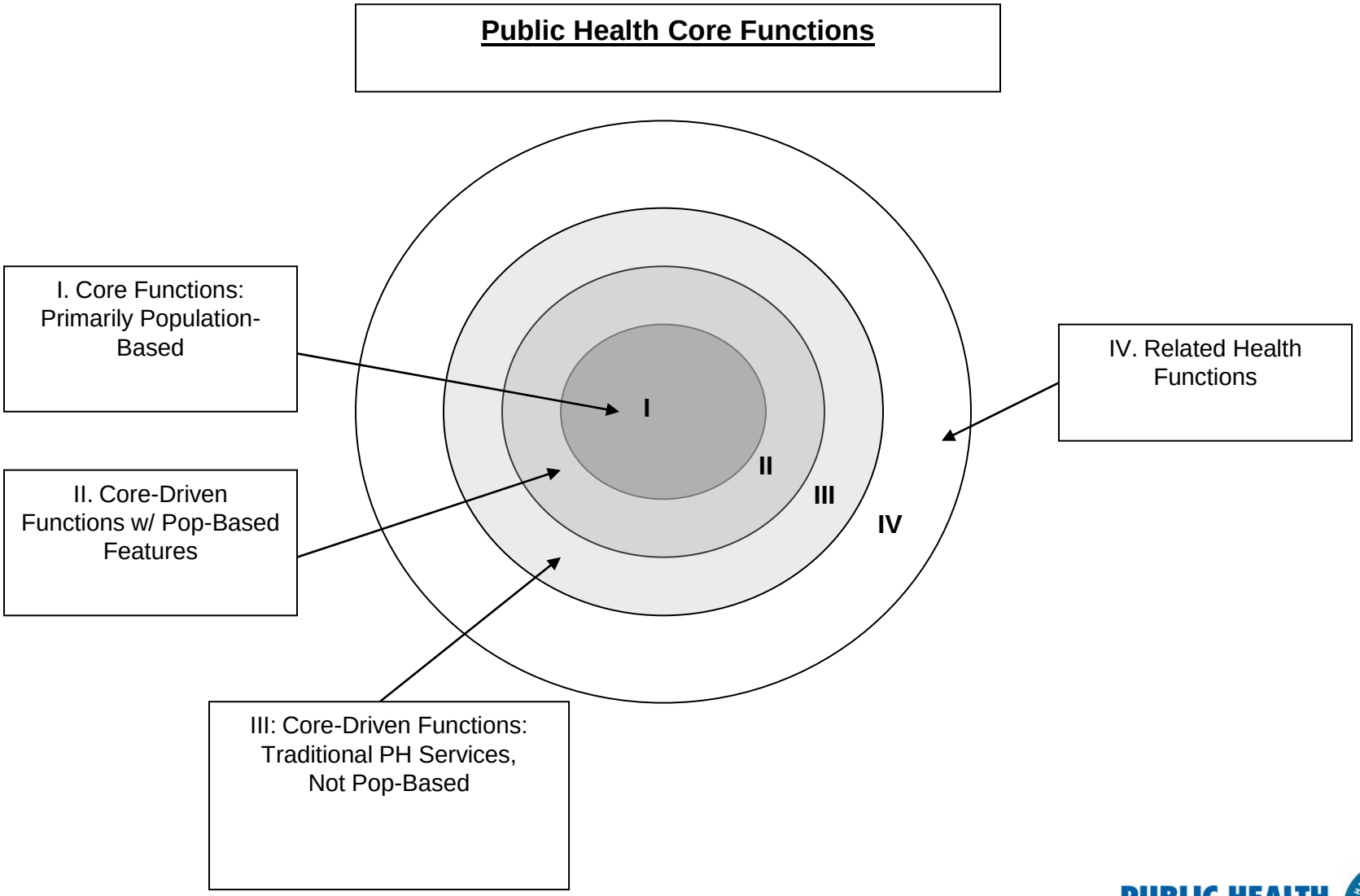
Level 3 Examples:
Core-Driven Traditional PH Functions Not Substantially Pop-Based

- Home Visit Nursing [1,1,1]
- Family Planning [1,1,1]
- ***Smoking Cessation*** Services [1,1,1]
- WIC [1,1,1]
- Case Management (for HIV, CSHCN, gen'l health care, etc.) [2,1,1]
- Oral Health Peds Screening/Preventive Tx [1,1,1]

Level 4 Examples: Related Health Functions that Could Be Delivered by PH

- Primary care, when not otherwise sufficiently available locally [1,1,1]
- Other health related services delivered under contract from various organizations. [1,1,1]

Public Health Boundaries:



Implications for LHJs:

- Level 1 Core Functions must be served in each community to have a minimally adequate public health system.
- Level 1 excludes some familiar public health functions. But, like healthy ears, eyes and limbs, they are still important.
- A local board of health, equipped with a health department staff capable of the Level 1 Core Functions, will be driven to provide necessary functions from other levels, to the extent possible.
- This approach is consistent with – in fact, it assumes – a substantial degree of local control.
- Agreement on core functions does not eliminate local decision making, but strengthens it.

Implications for Funding:

- You could estimate the cost of providing Level 1 functions in communities of varying sizes.
- In a rational funding system, Level 1 Core Functions would be supported by sustainable funds, allocated with a population-based formula (perhaps with corrections for small populations).
- This base funding would be a mix of state and local funds (perhaps also federal).
- Functions in other levels could be funded with competitive grants/contracts or other similar categorical funding approaches.
- This is the basis for credible proposals for a rational public health funding system.
- May work better than “we do good, so give us money.”

Beyond LHJs

- This discussion focuses mainly on local public health, but the population-based principle can help define the role of state health departments, too.
- DOH managers have found this approach useful over the last few months in deciding how to handle recent budget cuts.

Where are we trying to go?
We envision:

- ✓ **A governmental public health system delivering (at a minimum) core functions in every community.**
- ✓ **A *Public Health Compact* between state and local governments, which recognizes the differing capacities of each level of government, and clearly defines each party's responsibilities for core public health functions.**

How Do We Get There?

- ✓ **A sustainable governmental public health system is not likely to arise spontaneously.**
- ✓ **It's up to public health community to make it happen.**
- ✓ **It could take years, but to not make the attempt assures failure.**

WSALPHO recently adopted the following agenda:

Objective 1: Develop clear and practical proposals for a sustainable governmental public health system.

- Clearly define core functions, cost them out, develop funding options, express these ideas in a concise professional prospectus for the Public Health Compact.

Objective 2: Develop a realistic multi-year strategy for adoption of the *Compact* by state/local gov't.

- Requires careful planning with WSAC, DOH and other key partners.
- Must understand the *Compact* not as a proposal for one particular leg session, but as a long term goal for the governmental public health system.
- A goal important enough to stick with for a decade if that's what it takes.

Let me say that again:

A goal important enough to stick with for a decade if that's what it takes.

What's next?

At this point, these are just ideas.

WSALPHO and DOH are working on a series of discussions with key public health leaders to refine them.

The approach will probably evolve, but I wanted you to know what I am saying about it to my colleagues.

The End (so far)